



AGENDA ITEM

6.6

QUALITY & SAFETY COMMITTEE

LEARNING FROM MORTALITY REVIEWS

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Esther Flavell – Clinical Lead for Mortality Review, Natalie Morgan Thomas – Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness and Matthew Smith – Clinical Audit Manager
Presented by	Dom Hurford, Interim Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS

MR	Mortality Review
ME	Medical Examiner
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
PoWH	Princess of Wales Hospital
HMR	Hospital Mortality Review (Previously Called Stage 2 Mortality Review)
CA&QI	Clinical Audit & Quality Informatics

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to update the Quality and Safety Committee of the way Cwm Taf Morgannwg University Health Board captures and disseminates the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.
- 1.2 Cwm Taf Morgannwg University Health Board are in line with the All Wales Learning From Mortality Review Model Framework (September 2021). The advent of Medical Examiners (MEs) has given an opportunity for NHS Wales to look at how mortality reviews can be conducted to maximise learning, prevent future harm and improve the experience of patients, families and NHS staff. The Framework aims to provide a co-ordinated and systematic all wales approach to the mortality review process to enable local and national implementation of learning.
- 1.3 MEs are independent to organisations, HBs and Trusts and will review all deaths other than those that are covered by HM Coroners. They will refer any concerns identified at their initial review, to the relevant Health Board. This provides an objectivity to the reviews undertaken
- 1.4 Upon receipt of an ME referral, the organisation will decide on the most appropriate process for managing cases that have been sent to them by the ME. This is the responsibility of the CTM Multidisciplinary Mortality Review Screening Panel that went live on 1st April 2022. This coincided with the "Go Live" date for the Mortality Review module within DATIX that assists with capturing this information in a more systematic way as well as themes for learning opportunities. This is a whole Cwm Taf Morgannwg University Health Board Panel ensuring all deaths that need to be reviewed follow the same process within each Service Group.

The table below outlines the number of deaths referrals received from 1st April 2022 to 30th September 2022, the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed Pending Feedback	Closed
CTMUHB	610	21	255	2	332

- 1.5 Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate

make safe cases are instantly communicated to the directors of the Service Groups and Directors of nursing if required. Going forward the mortality review module within DATIX will assist us with capturing this information in a more systematic way and each learning point will have an action plan assigned to it.

2023 will see the introduction of biannual learning from MR events across CTM. In addition, quarterly lunch and learn events will be established quarterly to promote the newly released newsletter.

Learning from Mortality Reviews

- 1.6 Medical Examiner Service is currently reviewing approximately 95% of all Cwm Taf Morgannwg University Health Board, in hospital deaths. Accident & Emergency Departments remain the final areas to utilise this service. These deaths are still currently reviewed via the Universal Mortality Review (UMR) process, previously known as Stage 1 Mortality Review.

The table below outlines the number of deaths for each of the 3 localities from 1st April 2022 to 30th September 2022, the number where an initial review has been undertaken (either by ME or UMR), and the number and percentage outstanding.

	Total Deaths	Number Reviewed	Number Outstanding	Percentage Outstanding
Bridgend	490	475	15	3%
Merthyr	485	473	12	2%
Rhondda	535	521	14	3%

- 1.7 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued in RGH & PCH, albeit within a limited capacity due to the availability of clinical reviewers during the Covid19 pandemic. POW has very recently established a weekly panel and is in the process of clearing the backlog of cases. The table below shows the number of cases identified for HMR for each of the 3 localities from 1st April 2022 to 30th September 2022, the number where the review has been completed and the number and percentage outstanding.



	Number of HMR	Number Complete	Number Outstanding	Percentage Outstanding
Bridgend	88	30	58	66%
Merthyr	78	37	41	53%
Rhondda	119	40	79	66%

It should be noted that HMR panels are assisting with the completion of Wave 1 Hospital Acquired Covid reviews. This has impacted on the number of post April 2022 deaths that can be reviewed in each session

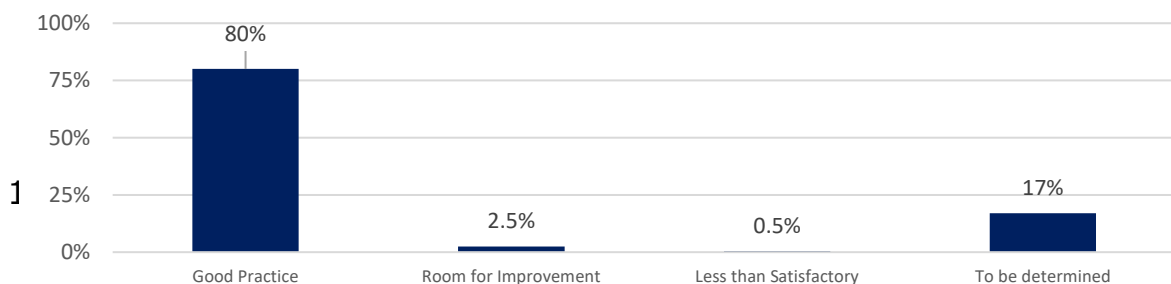
There are also a number of cases outstanding from:

2021-22 - Bridgend 87, Merthyr 104 & Rhondda 58.

2020-21 - Bridgend 178, Merthyr 68 & Rhondda 139. *290 of these cases relate to Hospital Acquired Covid-19 and will be completed by the Central Covid Team

- 1.8 Stage 3 Mortality Review panel was suspended during phase 1 & 2 of the Covid19 pandemic. Panels are now held on a monthly basis via Teams. There are currently 33 cases either waiting to be reviewed or in progress. Stage 3 functionality will be reviewed upon completion of the current backlog.
- 1.9 The DATIX mortality review module triangulates learning from mortality reviews with incidents and complaints to provide a complete picture. Action plans can then be devised considering all elements of the findings, and assurances given with progress made against the action plan. Mortality review findings are collated on completion. An Outcomes section is currently in development and expected 1/10/22. Upon release this will enable us to create a Mortality Dashboard for easier access to learning from death and wider dissemination. The graph below highlights Mortality Findings for 2022-23 so far.

Graph MR01: Mortality Findings as a % of All Deceased Patients





- Communication - many referrals could be avoided with improved communication with patients and relatives. Ensure clear communication regarding diagnosis to better prepare for decision making in regard to the patient
- Peri-operative Physician – previously noted to the Health Board as an urgent concern. Cases continue to highlight the lack of this service in RGH & PCH, which does not comply with Welsh Government standards on provision of care. It should be noted an Orthogeriatrician has been appointed at POW and are taking over the care of all fractured neck of femur patients soon, so it's likely that there may be improvements seen there. Arrangements continue to obtain Orthogeriatric services in PCH too.
- Improvements in End of Life Care - De-escalation / capping of care should be discussed and agreed earlier in the patients' admission in many cases being reviewed. Continuation of observations/NEWS after the decision was made for TLC only. ME service regularly notes NEWS (National Early Warning Score) continuing inappropriately when SEWS (Symptom Early Warning Score) should be considered. Inappropriate/Unnecessary investigations for patients who are being kept comfortable for end of life care. Missed opportunities to alert family members of deteriorating patient enabling them to attend the ward when end of life is imminent.
- Offload Delays at A&E Departments – highlighted as a concern for patients whose observations are worsening. Severe pressures on A&E Departments are noted
- Improvements in DNACPR Process – DNACPR discussions could take place earlier in patient's episode of care. In many occasions recently, DNACPR forms have been completed by junior doctors only without countersignature by Consultant/Senior doctor
- Gentamicin Prescribing and Monitoring – noted to be less prone to gentamicin error at RGH/PCH as there is a well-established practice involving a separate chart that prompts levels and has a nomogram to assist dosing. This is not the case in POW. Antimicrobial guidelines are currently in the process of being consolidated in to one health board wide guidance.
- Sepsis protocols need to be followed - There have been a number of recent cases recently where this has not been initiated soon enough. Immunosuppressants should be discontinued when treating a patient with sepsis.

- Frailty - Improved care in the community for patients with known frailty would reduce the number of potentially avoidable admissions
- 1.11 Currently, learning opportunities are fed back to the clinical teams or to the heads of nursing directly. With the use of the new DATIX module and the learning element of that system, this will allow clinical teams opportunities to devise action plans for sharing with the wider clinical work force. All actions will be routinely updated on the DATIX system to provide the required assurance for the organisation.
 - 1.12 When a case has not been resolved in the first two levels a proportionate investigation should be arranged. The scale and scope of the investigation should be proportionate to the case to ensure resources are effectively used. Cases which indicate the most significant need for learning to prevent serious harm should be prioritised.
 - 1.13 CTM will progress to level 3 when key issues and corrective actions have been identified, which could ultimately prevent or reduce the likelihood of the case recurring, providing assurance that risks have been reduced so far as is reasonably practicable, to ensure that appropriate control measures have been identified.
 - 1.14 In line with the principles of Putting Things Right, we should investigate once and investigate well, ensuring the investigation is thorough, systematic and avoids shortcuts that negatively impact on the final outcome of the quality and findings of the investigation.
 - 1.15 A summary of the learning from mortality reviews are shared throughout the Health Board via a quarterly newsletter and uploaded to SharePoint, noting common issues that have occurred within specific services or sites and across multiple services or sites. There will also be bi-annual learning events held in Cwm Taf Morgannwg University Health Board to discuss the learning from mortality reviews. These findings may lead to further thematic reviews of cases that share common factors. Direct feedback is provided to clinical and nursing teams as and when required.
 - 1.16 Learning is often considered as a 'one off' event where the problem is focused upon for a short time but moves onto new priorities as they emerge, often losing sustained learning. Consequently the action plans made following mortality reviews should be measured over time as part of a core clinical governance review programme. Until the Once For Wales/DATIX system is fully utilized, all action plans as a result of mortality reviews should be maintained by governance teams and feedback

should be given to the Clinical audit team, for assurance and transparency.

- 1.17 Work is in progress to link the findings from the MR process with the Health Board quality improvement programme of work.

Ongoing Development

- 1.18 Cwm Taf Morgannwg University Health Board wide Mortality Review Screening Panel live from April 2022, consisting of representatives from each Locality (Clinical and non-clinical, Primary Care, Palliative Care, Welsh Ambulance Service and Local Authority. Process maps continue to be developed in light of organisational restructure. Feedback templates and procedures for next of kin feedback (where requested) also currently in development.
- 1.19 Discussions are ongoing to ensure all ME Referrals are available to, and involving local teams as a first off for investigation of deaths so learning starts with them
- 1.20 DATIX Mortality Module updated 1st October with the inclusion of Outcomes section. Training continues to be delivered to all personnel with a responsibility for inputting to / updating / maintaining the module.
- 1.21 Further recruitment of clinical reviewers across CTMUHB to attend mortality review sessions in order to undertake all hospital mortality reviews, as identified by screening panel, in a timely manner. Training is available and will be provided to each reviewer. Approximately 75 members of staff across CTMUHB have received Mortality Review training. MR training is available to clinical teams and the nursing workforce via MST monthly. Bespoke training is also available on request. Recent feedback provided by Senior Nursing staff in POW has highlighted that those staff that have attended Mortality Review panel have enjoyed and felt that being involved is useful to their own practice and being able to use their knowledge and experience to support decisions.

The Medical Director currently finalising plans to make MR part of Consultant appraisal. It's likely to take a while to embed this but will play a major role in improved engagement.

- 1.22 It has been agreed that a resource is required for coordination of Mortality review activity across Cwm Taf Morgannwg University Health Board, but there is no funding currently available. This is an important role in triangulating, all activity from point of Medical Examiner referral onwards, including coordination of screening panel, oversight of DATIX module, coordination of hospital mortality review sessions, ensuring actions are completed and

dissemination of information and learning. Resource paper submission to suitably resource service needs

- 1.23 From 1st April 2023 all deaths with the Community will be reviewed by the Medical Examiner Service. It is felt this will have a substantial impact on the current Mortality Review Service as the number of ME referrals will likely increase considerably. This needs to be taken into account for future resource planning.

Baseline Population Numbers

- 1.24 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2020 for population of local areas to Cwm Taf Morgannwg University Health Board

Area	Estimated pop 2020	People/km 2020
Bridgend	147 539	588
RCT	241 873	570
Merthyr	60 424	542

- 1.25 The table below shows the number of deaths per area for each month of 2022 for each local authority area. Again, the data sets are form the ONS using their 2022 dataset.

Deaths per region 2022(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug
Bridgend	135	128	148	131	147	117	124	132
RCT	218	186	219	176	241	186	234	219
MCT	65	57	70	66	53	67	42	46

ONS data for deaths per month for Wales 2022

Month	Deaths	COVID	Age SMR
Jan	3262	237	311
Feb	2730	121	196
March	3203	133	207
April	2894	166	255
May	2992	100	150
June	2740	37	62
July	2638	106	176
August	2931	87	144



1.26 We would also like to reassure the committee that Wales has a robust MR Service looking at all deaths via the medical examiner. This is unlike the system in England where a proportion of deaths is looked at rather than each one. As a result of this, we are in contact regularly with the medical examiners who raise thematic concerns such as particular drugs or infections of concern. We are not aware of any highlights of specific specialties of concern to date.

1.27 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

From Gov.Wales: "In July 2014, Professor Stephen Palmer's review of the use of risk-adjusted mortality data in NHS Wales was published. He concluded the risk-adjusted mortality index (RAMI) was not a meaningful measure of hospital quality in Wales and its use could divert attention away from more meaningful approaches to measuring and improving hospital care"

1.28 The ONS does not publish data on days of admission, only days of death. We are unable to look at data such as day of admission and effect on death rates or deaths per specialty at the current time. This could be incorporated into further reports but would require more administration time and notes reviews. It should be noted though, that as all hospital deaths in Wales are reviewed, themes of relevance such as sepsis are sought, and there is a good working relationship with the medical examiners office, highlighting areas of concern.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Health Board is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

2.2 Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)



- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins

2.3 Intrinsic:

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: Safe Care, Effective Care, Dignified Care Timely Care, Staff and Resources
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below. Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goal	Improving Care

4. RECOMMENDATION

4.1 That the Committee **NOTE** the contents of the paper.